DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 - 0 1

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/00

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902 (a)(13)(c)(i) of the Medicaid Law

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 268 (1,533 x .6995 x .25)
b. FFY 2001 $ 891 (1,533x1.1x.7044x.75

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 3.1-A, Limitation Supplement, page 1a
ATTACHMENT 4.19-B, Page 1c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATTACHMENT 3.1-A, Limitation Supplement
Page 1a
ATTACHMENT 4.19-B, Page 1c

10. SUBJECT OF AMENDMENT:
Rates for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
Effective July 1, 2000

GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
J. Samuel Griswold, Ph.D.

14. TITLE:
Director

15. DATE SUBMITTED:
September 12, 2000

16. RETURN TO:
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 29, 2000

18. DATE APPROVED:
December 19, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Crosser

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

2.b. RURAL HEALTH CLINICS. Rural Health Clinic (RHC) services are limited to procedures performed by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. RHC services are covered when furnished to patients at the clinic, skilled nursing facility, or the patient's place of residence. Services provided to hospital patients (including emergency room services) are not considered RHC services. All services must be medically necessary and appropriate for the diagnosis and treatment of a specific condition. Reimbursement for RHC services is described in ATTACHMENT 4.19-B.

Supplies, lab work and injections are not billable services. These services and supply costs are included in the all inclusive rate. Family planning contraceptives and the technical component of x-rays and EKGs are not considered part of the all inclusive rate.

A maximum of twelve (12) visits per patient per fiscal year for patients age 21 or older.

2.c FEDERAL QUALIFIED HEALTH CENTERS. Federally Qualified Health Centers (FQHC's) services are limited to procedures performed by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. FQHC services are covered when furnished to patients at the center. These services are to be reimbursed at an all inclusive rate based on 100% of Medicare reasonable costs and other constraints as identified in paragraph 2(c) of 4.19-B. Services provided at a skilled nursing facility, hospital (including emergency services) or a patient's place of residence are not considered FQHC services.

Supplies, lab work and injections are not billable services. These services and supply costs are included in the all inclusive rate.

A maximum of 12 visits per patient per fiscal year for patients age 21 or older.

2.d Federally Qualified Health Centers. Federally Qualified Health Center services provided to a pregnant woman or an individual under 21 years of age will not be limited to 12 visits per patient per fiscal year.

2.e Indian Health Service (IHS) Facilities. Services reimbursed at the IHS rate are limited to procedures performed by a physician, physician assistant, nurse practitioner, nurse midwife or specialized nurse practitioner. These services are covered when furnished to a patient at the clinic. These services will be reimbursed at an all-inclusive rate as determined by the IHS.

Supplies, lab work and injections are not billable services. These services and supply costs are included in the all inclusive rate.

4.a. NURSING FACILITY SERVICES. (For individuals 21 years of age or older). Prior approval for admission (or upon request for payment) and prior approval for resident case mix classification as appropriate is the responsibility of the Division of Community Long Term Care, South Carolina Department of Health and Human Services (DHHS). Annual validation of resident case mix classification based upon a random sample of 20% of facility residents shall be performed for DHHS, under contract by the South Carolina Department of Health and Environmental Control (DHEC). Includes services provided in a swing bed hospital. Includes subacute care provided to ventilator dependent patients when contracted to provide this care (effective 04/01/89).

IV. Payments to Out-of-State Providers:

Payments to out-of-state providers shall be made based on the lesser of the fixed fee specified for the service or the charge for the service in the case of surgery, nonsurgery or treatment, therapy and testing services.

2b. Rural Health Clinics:

Reimbursement for medically necessary services will be made at 100% of the all-inclusive patient encounter fixed rate, per visit, as established by the Medicare Regional Intermediary. Provider based Rural Health Clinic's (RHC's) with less than 50 beds will receive reimbursement at 100% of Medicare reasonable costs not subject to the RHC rate cap, as established by the Medicare intermediary. A copy of the actual costs and utilization reports shall be submitted to this agency at the end of each fiscal reporting period to enable us to determine the reimbursement due for the fiscal period.

Services rendered to individuals age sixty-five (65) or older, and disabled, who are eligible for benefits through the Medicare program, will follow the Medicare billing procedures established by the Regional intermediary. Coinsurance and Deductibles will be paid by the Medicaid (Title XIX) program where the individual has joint eligibility under both programs.

2c. Federally Qualified Health Centers:

The South Carolina Department of Health and Human Services (DHHS) will accept the Modified Medicare Cost Report for Rural Health Clinics as the cost report format for the Federally Qualified Health Centers in South Carolina. The reports, as submitted, shall be reviewed for accuracy, reasonableness, and the allowability of costs as defined by Medicare reasonable cost principles. Reimbursement will be made at 100% of Medicare reasonable costs with the following constraints: (1) The minimum productivity level shall be for the provision of services from 22 to 27 patients per day; (2) Overhead costs shall be limited to not more than thirty percent (30%); and, (3) Out-of-state Federally Qualified Health Centers shall be paid the statewide average encounter rate as determined from the most recently completed state fiscal year. To ensure that reimbursement will be made at 100% of Medicare reasonable costs, subject to the above mentioned constraints, adjustments to cost shall be made on a retrospective basis based upon our review of the provider's FYE cost report. Furthermore, the reported information shall be utilized for establishing or modifying the rates of payment for future services rendered by the Federally Qualified Health Center. For those facilities that are not PHS grantees but are designated as "look alikes," the same cost principles and constraints shall apply as mentioned above for the Federally Qualified Health Centers.

2e. Indian Health Service (IHS) Facilities:

Effective July 1, 1999, DHHS will reimburse IHS facilities (638 facilities) at the rate as determined by the Indian Health Service. For Calendar year 1999, the rate is published in the Federal Register/Vol.64, No. 16/Tuesday, January 26, 1999/Notices, page 3955. Subsequent year rates shall be announced in the Federal Register. The rate shall be an all-inclusive encounter rate per visit for the provision of medically necessary out-patient services provided to both Native and non-Native Americans.

Coinsurance and Deductibles will be paid by the Medicaid Program (Title XIX) program where the individual has joint eligibility for Medicare and Medicaid.